University of Alberta

Impact of Health Care Restructuring on the Role of the Nurse Manager

by

Kimberly Ann Campbell ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Nursing

Faculty of Nursing

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **Impact of Health Care Restructuring on the Role of the Nurse Manager** submitted by Kimberly Ann Campbell in partial fulfillment of the requirements for the degree of Master of Nursing.

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ABSTRACT

There is general agreement in the literature that the first-line nurse manager is essential to the success of providing patient care services. A descriptive design was used to determine the impact of restructuring on the role of first-line nurse managers working in institutional settings. A total of 79 nurse managers responded to a survey questionnaire. Generally, these nurse managers had large portfolios with wide spans of control, budgets greater than two million dollars, and numerous classifications of staff reporting to them. In light of the expanded scope of responsibilities, there seemed limited administrative support in terms of computers, assistant managers, and secretarial assistance. There was also diminished educator support, particularly in the rural areas. Further study is recommended to research the larger scope of responsibility of the nurse manager and impact on patient and staff outcomes.

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Introduction

The health care system in Canada is experiencing unprecedented change. The concurrent reduction in health care resources, restructuring of the system are occurring at a pace and magnitude seldom seen before in this country. Most, if not all, provinces are experiencing significant restructuring of health care services due mainly to the decline in the amount of funding contributed by the federal and provincial governments. These changes have created widespread debate and discussion in political, social, economic, professional, and academic circles. For many health care providers, at both staff and management levels, there is considerable anxiety about the consequences of massive restructuring.

There is general agreement in the literature that the first-line nurse manager role is essential to the success of providing patient care services. The nurse manager has been described as a linchpin in hospitals' efforts to improve patient care and control costs (Eubanks, 1992). The nurse manager serves as a vital link between the delivery of quality patient care and the larger vision of the health care institution. Role responsibilities of this position include: management of clinical nursing practice and patient care delivery; management of human, fiscal and other resources; staff development; compliance with professional and regulatory standards; strategic planning, and fostering collaborative relationships within interdisciplinary teams (Aroian et al. 1997).

The current health care environment poses particular challenges for nurse managers. While expected to lead and facilitate change, nurse managers often find themselves caught in the middle of these changes (Coulson & Cragg, 1995). Nurse managers are being challenged to do more with less: maintaining or improving patient

care services with declining human and financial resources (Dick & Bruce, 1994). Anecdotal reports suggest that many first-line positions have been eliminated, but little objective information is available i.e., overall figures. Little is known about current first-line nurse managers, that is, their role, positional titles, educational preparation, and span of control within this restructured health care environment. If this role is central to the operation of health care institutions, it would be prudent to assess what impact these changes have had on the roles and responsibilities of nurse managers.

The research in this document relates to the description of the roles and responsibilities of first-line nurse managers in the province of Alberta. The thesis consists of an introduction and three sections. The first section is a review of the literature that served as a basis for the study. The second section is a summary of the research prepared as an article for submission to a nursing administration journal. The final section is a reflection on additional findings that could not be accommodated in the paper prepared for publication.

The specific research questions to be addressed are:

(1) What are the self-reported characteristics of first-line nurse managers currently employed in Alberta?

(2) What are the self-reported roles and responsibilities of first-line nurse managers currently employed in Alberta?

(3) What are the relationships between the roles and responsibilities and the characteristics of first-line nurse managers?

(4) What are the perceived impacts of health care changes for first-line nurse managers?

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Background to Study

The background to the study will be presented as follows: first, health care changes in Canada and Alberta are described to provide the context for the working environments of first-line nurse managers. In the second section, general implications of health care restructuring for nurses in administrative roles will be explicated. Then a literature review of the role of the first-line nurse manager will be presented. Definitions, positional titles, span of control and educational preparation of the role will be reviewed. Finally, future implications for nurse managers in the context of health restructuring will be outlined.

Context of Study

Health Care Changes in Canada

Canadians do not have a single national health care system. Health care is primarily under the provincial and territorial jurisdiction. Each province and territory is able to define and provide health care services within the broad criteria of the Canada Health Act. Thus health care plans differ from province to province, and given the current climate of change these differences are likely to increase (DiMarco & Storch, 1995). Declining federal support and falling tax revenues have curbed the capacity of provinces to finance government programs (Rachlis & Kushner, 1994; Storch & Meilicke, 1994). This has led to profound and rapid changes for health care systems in Canada (Donner, 1995). Hospitals tend to be the primary target of these changes. Governments have chosen to limit resources to acute care institutions, and the result of this intervention has been bed closures, staff layoffs, program cancellations and a restructuring of the workforce (Dick & Bruce, 1994).

There is an attempt across Canada to shift health care from a curative to preventative approach, from specialized care to primary health care, and from provider focus to patient-centered focus (Ross, MacDonald, McDermott & Veldhorst, 1996). In the wake of these anticipated changes, traditional health care structures are being replaced by structures that attempt to improve quality while cutting costs (Curtin, 1995; Doerge & Hagenow, 1995; Heenan, 1989; Smith, 1994; Triolo, Allgeier & Schwartz, 1995). Restructuring is often viewed as an adaptive response by health care systems to environmental changes (Alexander & Orlikoff, 1987; Gerber, 1983; Hoch, 1984). Decreased funding, complex regulations, increased competition and reimbursement issues are all considered to be factors in the movement toward restructuring (Ernst & Whinney, 1982; Gerber, 1983; Porter, 1981). Some authors even describe restructuring as necessary for the survival of health care systems (Ernst & Whinney, 1982; Fitzgerald, 1985; Porter-O-Grady, 1996; Rachlis & Kushner, 1989). However, there is little agreement on how health care systems should be restructured (Rachlis & Kushner, 1994).

Six global issues have been identified as having a significant impact on health care providers, including managers, as health care systems continue to change. First, changes to funding mechanisms between federal and provincial governments are changing the scope in which health care services are managed. Second, the implications of more autonomous provincial health care systems in relation to the concept of a national health care system must be considered. Third, there is a preoccupation within restructuring health care management activities. Fourth, there is competition between consumerism and evidence-based practice. Issues will continue to rise given the emotional element of health care to individuals. Fifth, the use of information and quality improvement tools will

increase the level of measurement of effective health care systems. Finally, an underlying set of competing values, philosophies and ideologies continues to permeate the preceding issues (Canadian College of Health Care Executives, 1996).

The Alberta Experience

Changes in economic and political circumstances in the province of Alberta, significantly reduced funding to most health care institutions in the summer of 1995 (Jackson, 1995). Despite the abruptness of the funding changes, the restructuring of Alberta's health care system was not a new concept. In December 1987, the former Premiere of Alberta, Don Getty, established the Premier's Commission on Future Health Care for Albertans (Alberta Government, 1987). Two years later, the final report was tabled in the form of "The Rainbow Report: Our Vision for Health" (Alberta Government, 1989). The recommendations from this report have, to a limited extent, provided the blueprints for change in the current health care system. The formation of seventeen Regional Health Authority Boards occurred in July 1994. The restructuring of Alberta's health system was deemed necessary to ensure that it was affordable, sustainable and responsive to the health needs of Albertans (Alberta Health, 1994). The primary impetus for these changes has been the reduction of budget dollars from the government (Capital Health Authority, 1995a). Human resource costs tend to make up a major portion of budgets, and therefore, cost containment has come in the form of layoffs of both staff and managers. Layoffs have resulted in the net loss of 100 manager/ administrative staff which is a 30 per cent reduction in the Edmonton area alone (Capital Health Authority, 1995b). Staff reductions by March 31, 1996 have totalled 1,100 full

time equivalents, but the actual numbers of staff affected are unknown (Capital Health Authority, 1996).

Alberta Health's three year business plan tabled in February 1996, targeted expenditure reductions totaling 548 million dollars. However, it was reported that in June 1996, an additional 210 million will be added in the years 1997 to 1999 (Canadian College of Health Service Executives, 1996). The Alberta Government maintains that the additional dollars will go to direct services for Albertans and front line workers (Alberta Health, 1997). While the government admits the changes have been a challenge to Regional Health Authorities and administrators, the priority for spending will be toward health services for Albertans. The government is firm in its commitment to further reduce administration costs. These efforts to reduce administration costs will continue to impact all levels of nursing management in the Alberta Health system. O'Malley (1996) suggests many health care organizations and acute hospitals in particular, have been unprepared for the major reforms and operational restructuring expected during this time of unprecedented change.

Literature Review

The Nurse Manager in the Context of Health Care Changes

Perspectives on middle and executive level nurses in the context of North American health care restructuring are generally well documented (Skelton-Green, 1995; American Organization of Nurse Executives, 1993; Bernard & Walsh, 1995; Byers, 1997; Barnum & Kerfoot, 1995; Ross, MacDonald, McDermott & Veldhorst, 1996; Pinkerton, 1996; Zavodsky & Simms, 1996; Kirk, 1987; Fralic, 1992; Patz, Biordi & Holm, 1991). Little scrutiny has been given to first-line managers, who function at the managerial level

closest to the patient (Johnson, Anderson, Helms, Hill & Hanson, 1995). Until recently nurse managers have been overlooked by researchers and educators. Nursing journals are filled with many anecdotal articles discussing the role, but little research exists regarding nurse managers or the nurse manager role (Pedersen, 1993). Some studies about the general nature of the nurse manager role are provided in the literature. Often these studies try to identify different tasks within the role, but there is no consistency from study to study. Sample sizes are small, making generalizations difficult. Survey questionnaires have been the most popular methodology, but respondents have only been asked to rank agreement about predetermined activities, leaving any other activities unaddressed.

Many researchers have acknowledged that the nurse manager role is essential to the success of providing nursing services (Beaman, 1986; Bunsey, DeFazio, Pierce & Jones, 1991; Patz, Biordi & Holm, 1991). The first-line nurse manager has the unique role of combining the knowledge of management and nursing by providing liaison between the staff at the unit level and senior administration (Coulson & Cragg, 1995). In the last ten years, the role of the nurse manager has significantly expanded (Lee & Henderson, 1996; Kilpatrick & Dick, 1995; McClosky, Gardner, Johnson & Mass, 1988). Scope of practice has increased, within the institutional settings, due to consolidation and restructuring of health care services. Nurse managers have taken on corporate responsibilities as well as routinely supervising nurses, other professionals and support staff (Kilpatrick & Dick, 1995; McClure, 1985; Wagner, Henry, Giovinco & Blanks, 1988).

Implications for Nurse Managers

Vaill (1989) uses the image of permanent white water to describe the chaotic environment of change in which most organizations, including health care, currently find themselves. In permanent white water, one never leaves the rapids, one change follows the other, often the changes overlap and there is no opportunity to recover. Psutka (1989) suggests that the consequences of this environment are anxious patients, angry physicians and beleaguered administrators. Skelton-Green (1995) proposes that effective leadership is required to navigate through these turbulent times. Organizations require managers who are committed, who have a long-term vision of what their institutions wish to accomplish, and above all, who are able to empower their staff to achieve this vision (Triolo, Allgeier & Schwartz, 1995; Sanders, Davidson & Price, 1996; Lee & Henderson, 1996).

Giving nurse managers the responsibility to empower and influence direct caregivers means that senior management must relinquish some control over operations. Senior hospital managers are beginning to recognize that nurse managers are key in efforts to combat low morale, high turnover and decreased productivity (Eubanks, 1992). Given that nurse managers appear to be key players in health care organizations, it is important to determine the impact of health care restructuring on this group. Yet, there persists a lack of clarity and ambiguity about the role of the nurse manager. Furthermore, nurse managers themselves are unable to articulate the responsibilities and expectations of their roles in the environment of health care restructuring (Nicklin, 1995).

The Role of the Nurse Manager

Nursing Administration Model

Within the continually changing health care environment, the role of the nurse manager becomes more complex. Nurse administrators represent and interpret nursing as an essential component of the health care organization (Blair, 1989). In response to the demand from its membership, the Canadian Nurses Association developed a guiding document for all nurse managers (Haines, 1993). Originally developed in 1983, the document was revised in 1988 underscoring that health care changes were having an impact on the scope and nature of administrative practice.

The Canadian Nurses Association (1988) views the role of the nurse manager as two dimensional: professional and corporate. The professional dimension refers to knowledge and expertise specific to the practice of nursing, advising on nursing matters, and providing nursing leadership. The corporate dimension refers to the participation of the manager in the administrative team for the purpose of allocating resources, determining policy, and other general management issues. The administrative level usually determines the relative weight of each dimension. For example, the professional dimension would be greater for the first-line nurse manager whereas the corporate dimension would be greater for the nurse at an executive level. The key issue for nurse managers is not whether to be clinically skilled or administratively competent, it is the integration of both that is critical (Porter-O'Grady, 1993).

Definition of Nurse Manager

Definitions of the first-line nurse manager vary considerably in the nursing literature. Some authors define the nurse manager as an individual who has 24 hour accountability or responsibility for one or more patient care areas (Goldberg & Buttaro, 1990; Johnson, Anderson, Helms, Hill & Hanson, 1995; Mark, 1994; Pedersen, 1993; Zavodsky & Simms, 1996). Kilpatrick and Dick (1995) define the nurse manager as a registered nurse in a first-line or middle management position with various members of the health care team reporting to him or her. Coulson and Cragg (1995) only refer to the nurse manager as one who is a liaison between the unit and upper levels of administration. In a slightly different vein, Stevens (1983) suggests that the nurse manager, or in this case the head nurse, applies the policies and procedures of the institution to concrete situations on a given patient care unit. Other authors define the nurse manager in terms of delineating the particular operational responsibilities of the position. These responsibilities include patient care management (Zavodsky & Simms, 1996), delivery of therapeutic and cost-effective patient care (Beaman, 1986; Westmoreland, 1993), supervision and direction of staff (Acorn & Crawford, 1996; Beaman, 1986; Zavodsky & Simms, 1996; Goldberg & Buttaro, 1990) and financial management/fiscal responsibility for human and material resources (Acorn & Crawford; 1996; Zavodsky & Simms, 1996, Stevens, 1983; Westmoreland, 1993). For the purpose of this review, the first-line nurse manager will be defined as a registered nurse who holds the lowest administrative position within an institutional setting. This individual is actively engaged in the management of patient services provided by nursing and other health care disciplines in a prescribed clinical or functional area of the institution. The first-line nurse manager has 24 hour accountability

for his or her defined patient care area. The primary role of the nurse manager is to provide leadership, guidance and support to nursing and other disciplines in the delivery of patient care.

Positional Titles

Numerous positional titles are used in the nursing literature to describe the first-line nurse manager. There is often confusion and inconsistency regarding the various titles to describe nurses in management positions. Duffield (1991) noted that the term head nurse is often used in North American literature. In addition to head nurse, Johnson, Anderson, Helms, Hill and Hanson (1995) found in a study of American rural nurse managers other titles describing the head nurse role: unit department head, charge nurse and clinical area coordinator. Furthermore, Pedersen (1993) reports clinical nurse, nurse manager, director of nursing and director of home health agency as various titles associated with the head nurse role.

A nurse manager's scope of responsibility can also include other disciplines and support services in addition to nursing, and so the title of head nurse or nurse manager does not appropriately describe the diverse role. Hence the titles of unit manager or patient care manager have been instituted (Litwin, Beauchesne & Rabinowitz, 1997; Fysh, 1996). Only two citations were located that referred to the title of patient care manager (Fysh, 1996; Parkman, 1996). Interestingly enough, Parkman (1996) refers to the patient care manager as a professional nurse in the context of the provision of patient care. This author identifies the shift manager and unit manager as positions responsible for staff, materials and systems.

It is clear from the literature that the term first-line nurse manager is used interchangeably with numerous positional titles all seemingly describing a similar role. Terminology seems to differ from organization to organization. The title of patient care manager is less clear and controversy exists in the literature whether this is indeed a title for nurse managers or for a professional staff nurse providing patient care. For the purpose of clarity, the nurse in a first-line management position is referred to as the nurse manager in this study.

Span of Control

Span of control is defined as the number of employees reporting to a supervisor or manager (Daft, 1989). The term was initially discussed by classical management theorists who were trying to determine the optimal span of control for managers. Management theorists are divided on the optimum span of control expected of one manager. Attempts have been made to quantify span of control with suggested ranges from three to 50 employees (Marquis & Huston, 1987). Fayol (1951) concluded that managers should have no more than five subordinates reporting to them, but did allow that in a "simple" operation, 20 to 30 workers could be supervised.

Woodward (1965) conducted a ten year empirical study of British Industry. This study has been described as pathbreaking work in relation to span of control (Munson & Zuckerman, 1988). Woodward (1965) found that first-line supervisors' span of control ranged from ten to 60 employees. Rather than trying to prescribe the optimum span of control, the author identified factors that influenced span of control. Span of control, in this study, was influenced by the type of production system utilized in the organization, the type of technology and the skill of the worker. To a lesser extent, the management

style of senior administration and the historical tradition of the organization influenced the number of direct reports to a first-line supervisor. Woodward found that span of control was not influenced by the size of the organization or the success of the organization. Span of control was found to be smaller in industries with increased technical complexity, larger numbers of highly skilled workers and where the labour force was divided into smaller working groups.

Twenty years later, it would appear that there is a renewed interest in prescribing spans of control for managers. In response to the decline in American industry, Peters (1987) suggests that management levels must be reduced and that minimum span of control at the front line should be 25 to 75 workers to one supervisor.

Little research has been done on span of control in nursing. McCloskey, Gardner, Johnson and Maas (1988) reported that a head nurse, in a large teaching hospital, could routinely supervise 20 to 25 staff. Acorn & Crawford (1996) found in a study of first-line managers in British Columbia, that the number of direct reports to an individual nurse manager ranged from four to 175 staff. In Alberta, anecdotal reports suggest that many nurse manager positions have spans of control in excess of 40 to 50 direct reports. The scope of the nurse manager has increased through program and service consolidation following regionalization. Only two articles were located describing span of control within nursing management. Hence there is little guidance available to administrators determining the span of control for first-line managers so that human and financial resources are used effectively and efficiently and that quality patient care is delivered. When faced with reduced budgets, managerial positions are often eliminated in order to retain caregivers at the bedside (Pabst, 1993).

Financial issues are only one dimension to be considered when changing span of control. Alidina & Funke-Furber (1988) identified nine factors influencing span of control for first line nurse managers: patient profile, nursing care program, geographical contiguity, manager profile, employee profile, job related factors, support systems, organizational factors and environmental factors. Patient profile refers to patient characteristics such as age, illness, complexity and duration of care needs. Nursing care programs refer to the philosophy, goals and objectives of the nursing department. Geographical contiguity is defined as the physical layout of the area to be managed. Manager profile includes the skills, experience and education of the nurse manager. Employee profile includes the mix of staff, training levels and competence. Job related factors refers to the functions of the nurse manager that is, clinical care services, human resources and fiscal management. Support systems refer to the existence of administrative support staff as well as the availability of policies and procedures. Organizational factors, such as size and complexity, have an impact on span of control. Environmental factors include social political, economic and technologic factors that can influence an organization (Alidina & Funke-Furber, 1988).

Pabst (1993) agrees that there are a number of variables that need to be considered when determining span of control. In addition to the aforementioned factors, the author suggests issues such as nurse satisfaction and retention be considered. She cautions that the examination of span of control should not be limited to the areas managed by nurses as other clinical and non-clinical departments also need to be evaluated. There appears to be no studies testing any of the proposed variables that may influence span of control of first-line nurse managers.

The Dilemma of the Nurse Manager: Clinical versus managerial role

During the early era of nursing management, expert clinicians were promoted to positions in nursing management. Preparation for the role was gained through on-the-job experience as formal education programs did not exist (Smith, 1988). Unfortunately, superior clinical skills did not always translate into excellent management abilities (Sanders, Davidson and Price, 1996). Nevertheless, the primary responsibilities of the nurse manager were clinical and management skills were secondary (Mark, 1994). Stevens (1983) suggests the nurse manager must be a clinical expert in order to direct and teach nursing staff and to maintain credibility among the staff as their leader. Duffield (1989) noted in her study of nurse manager competencies that the two highest ranked competencies of a nurse manager were related to patient care: ensuring the delivery of quality patient care and planning safe, cost-effective care. She also argues that these two competencies might be better attributed to someone in a clinical nurse specialist position.

There is more pressure for the nurse manager to take on more of the managerial dimension to facilitate quality outcomes in patient care and meet other strategic institution goals and objectives (Sullivan, Baumgardner, Henninger & Jones, 1994). For the nurse manager, one of the main obstacles to internalizing the concept of being a manager, is reconciling the role of the clinician with that of the manager (Sanders, Davidson & Price, 1996). An ethnographic analysis of the first-line manager's role was conducted in two American Hospitals. Most participants described themselves as being ill-prepared to take on the responsibilities of the manager role, learning mostly by trial and error. Some were fortunate to have mentors to support them in learning daily management activities (Everson-Bates, 1992). There have been attempts to develop programs to support this

1996). An ethnographic analysis of the first-line manager's role was conducted in two American Hospitals. Most participants described themselves as being ill-prepared to take on the responsibilities of the manager role, learning mostly by trial and error. Some were fortunate to have mentors to support them in learning daily management activities (Everson-Bates, 1992). There have been attempts to develop programs to support this transition from clinician to administrator (Litwin, Beauchesne & Rabinowitz, 1997; Pinkerton, 1996; Werkheiser, Negro, Vann, Holstad, Byrd & Von Talge, 1990). Yet, there seems to be no documented evaluation on the effectiveness or success of these programs. Moreover, two studies indicate that the nurse manager's role shift from clinical to managerial is only partially desired by nursing staff (Corser, 1995; Pederson, 1993).

Mark (1994) also indicates a debate over the structure of graduate nursing programs. She argues that graduate programs preparing nurse managers should not be preparing clinicians who take a token few management courses. The dilemma arises from whether it is more favourable to have the nurse manager carry out sophisticated nursing procedures or to attend to staffing, budget and other management needs.

While it is generally agreed upon in the literature that the nurse manager's role is in transition from a clinical focus to a more corporate one, there is little agreement on how this will be achieved, and some evidence that it is only partially accepted by staff.

Educational Preparation of Nurse Managers

Almost every era of nursing has seen the need for skilled and prepared nurses to assume nursing administration positions (McCloskey, Gardner, Johnson & Maas, 1988). A number of educational options exist in Canada for nursing administrators: an

undergraduate degree in nursing, continuing education certificates in nursing management and a graduate degree in nursing, health or public administration or business administration (Kilpatrick & Dick, 1995). The authors also note that changes in nursing education have been slow to reflect the new roles of nurses in management positions. Yet in order to remain competitive within the restructured organization, the nurse manager needs to be prepared at the graduate level (Braunstein, Young, & Beanlands, 1995; Duffield, 1991; Hibberd & Kyle, 1994; Johnson, Anderson, Helms, Hill & Hanson, 1996; Mark, Turner & Englebardt, 1994; Weil, 1996).

Two important issues are highlighted when reviewing the literature pertaining to the education of first-line nurse manager. First, as the nurse managers' role shifts from a clinical focus to a corporate one, nurse managers are generally unprepared to meet these challenges (Braunstein, Young, & Beanlands, 1995; Duffield, 1991; Kilpatrick & Dick, 1995). To illustrate this point, reported education levels of head nurses in Canada and Alberta was examined.

In Canada, the highest level of education reported by head nurses in 1989 was: diploma in nursing (63%), baccalaureate degree (13%), post-basic certificate (23%), graduate degree (0.8%). Education reported by head nurses in Alberta for the same year was diploma in nursing (46%), baccalaureate degree (24%), post-basic certificate (28%), graduate degree (1.5%) (Statistics Canada, 1989).

Data was also examined for the year 1995. Generally there is a pattern of increasing percentages of individuals obtaining baccalaureate and graduate levels of education. In Canada for the year 1995, the highest level of education reported by head nurses was diploma in nursing (72%), baccalaureate degree (25%), graduate degree

(1.83%). In Alberta, education reported by head nurses was diploma in nursing (64%), baccalaureate degree (31%), graduate degree (4.6%). There was no data reported in 1995 for post-basic certificate preparation (Statistics Canada, 1996).

The second issue in the literature is that there is no agreement on how to address this problem of appropriately preparing nurse managers. Many authors stress the need for advanced preparation, however different methods have been suggested to improve the educational preparation of nurse managers. Braunstein, Young, and Beanlands (1995) suggests graduate education programs with either an advanced core of nursing knowledge within an administrative framework or a core of administrative knowledge within a nursing framework should be considered. Mark (1994) concluded graduate programs require core nursing courses combined with administrative content and a supervised administrative practicum. In contrast, Duffield (1991) has identified several approaches, other than graduate education, to foster professional development including journal clubs, workshops, in-house courses taught by senior administrators, and leadership self-assessment tools from which programs can be developed. The educational requirements of the first-line nurse manager remain controversial and it is difficult to conclude that a master's degree is necessary (Fullerton, 1993).

Future Implications

A review of the literature concerning the role of the nurse manager reveals many issues. There is an apparent lack of standardized information about the nurse managers' role. There is much confusion in the literature about the definition of the nurse manager. There is a lack of consensus about what nurse managers do, the skills they use in

management work, the functions they perform, and the role that they play in restructured health care environments.

Nurses, including nurse managers, appear to have had little influence on the process and structure of health care restructuring.. Their initial concern seems to be adapting to the changed environment (Johns, 1996). Role modifications, that may not be appropriate, could be accepted rather than challenged. If nurse managers are having difficulty articulating their role and responsibilities, it is no wonder that other key players in health care organizations have an equally difficult time understanding the role. This lack of understanding has led the nurse manager to fulfill the requirements of a new role within a less than optimal environment. This role confusion can lead to frustration, lowered productivity, reduced risk taking, blaming, denial and burnout (Triolo, Allgeier & Schwartz, 1995).

Retention issues may also result from this dissatisfaction. Anecdotal reports suggest that recruitment has been difficult when filling positions when a nurse manager resigns. If nurses do not envision the nurse manager position as an attractive career path; a shortage of nurse managers will result. As well, there is potential for replacement by a generic health care manager who does not have a nursing background.

There is no agreement in the literature on what educational preparation is required for the position of nurse manager. Although there is agreement that additional preparation is required to prepare nurses to assume managerial positions, and to provide continuing education for nurses already in these positions. Few nurses that are prepared at a graduate level. An assessment of why nurse managers are not pursuing further

education needs to be explored. Then strategies could be developed to improve opportunities for learning that will attract nurses to obtain graduate education.

Conclusions

The role of the nurse manager has not been clearly defined, although many authors have attempted to do so. Multiple role titles continue to confuse the issue. Span of control appears to have increased, but there is little known about how this has impacted the role of the nurse manager. Many authors acknowledge the need to prepare the competent clinician with greater managerial skills especially in light of restructured health care environments. Ultimately the transition from a clinical position may be difficult and result in role conflict (Duffield, 1991).

Nurse managers have the best knowledge of patient care delivery and a broad perspective of the continuum of care (Beyers, 1995). There are high expectations of the nurse manager within restructured organizations. Nurse managers must adapt their skills to lead their organizations into the future. The transition from the traditional head nurse to an innovative nurse manager may be difficult. If the nurse manager role is indeed one of the most critical administrative positions, then development of the role is one of the most fundamental issues within a restructured organization (Nicklin, 1995). There is little research that addresses the changing role of the nurse manager within health care restructuring (Acorn, Ratner & Crawford, 1997). There is a clear need to promote research in this area to enhance understanding of the scope of the role and the skills and qualifications required to perform it.

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The Role of First-line Nurse Managers:

Impact of Restructuring

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The Role of First-line Nurse Managers: Impact of Restructuring

Purpose of Study

The importance of the nurse manager for both quality patient care and organization efficiency and effectiveness seems indisputable. Nurse managers have the best knowledge of patient care delivery and a broad perspective of the continuum of care (Beyers, 1995). If the nurse manager role is indeed one of the most critical administrative positions, then development of the role is one of the most fundamental issues within a restructured organization (Nicklin, 1995). There is little research that addresses the changing role of the nurse manager within health care restructuring (Acorn, Ratner & Crawford, 1997). The purpose of this study was to gain a better understanding of the roles and responsibilities of nurse managers within the environment of restructured health care institutions in Alberta. The target group was registered nurses who held the lowest administrative position in a prescribed clinical or functional area of an institution. The study provided the opportunity to study demographic characteristics such as age, geographical location (rural or urban centres), educational level, area of practice, length of practice and experience of the nurses occupying these roles.

Literature Review

There is an attempt across Canada to shift health care from a curative to preventative approach, from specialized care to primary health care, and from provider focus to patient-centered focus (Ross, MacDonald, McDermott & Veldhorst, 1996). In the wake of these anticipated changes, traditional health care structures are being replaced by structures that attempt to improve quality while cutting costs (Curtin, 1995; Doerge & Hagenow, 1995; Heenan, 1989; Smith, 1994; Triolo, Allgeier & Schwartz, 1995).

Perspectives on middle and executive level nurses in the context of North American health care restructuring are generally well documented (Skelton-Green, 1995; American Organization of Nurse Executives, 1993; Bernard & Walsh, 1995; Byers, 1997; Barnum & Kerfoot, 1995; Ross, MacDonald, McDermott & Veldhorst, 1996; Pinkerton, 1996; Zavodsky & Simms, 1996; Kirk, 1987; Fralic, 1992; Patz, Biordi & Holm, 1991). However, little scrutiny has been given to first-line managers, who function at the managerial level closest to the patient (Johnson, Anderson, Helms, Hill & Hanson, 1995).

Many researchers have acknowledged that the nurse manager role is essential to the success of providing nursing services (Beaman, 1986; Bunsey, DeFazio, Brown, Pierce & Jones, 1991; Patz, Biordi & Holm, 1991). The nurse manager has the unique role of combining two professions, management and nursing, by providing liaison between the staff and upper levels of administration (Coulson & Cragg, 1995). In the last ten years, the role of the nurse manager has significantly expanded (Lee & Henderson, 1996; Kilpatrick & Dick, 1995; McClosky, Gardner, Johnson & Mass, 1988). Scope of practice has increased, within the institutional settings, due to consolidation and restructuring of health care services. Nurse managers have taken on corporate responsibilities as well as routinely supervising nurses, other professionals and support staff (Kilpatrick & Dick, 1995; McClure, 1985; Wagner, Henry, Giovinco & Blanks, 1988).

A review of the literature concerning the role of the nurse manager reveals many issues and little consensus. There is much confusion in the literature about the definition of the nurse manager (Goldberg & Buttaro, 1990; Johnson, Anderson, Helms, Hill & Hanson, 1995; Kilpatrick & Dick, 1995; Mark, 1994; Pedersen, 1993; Zavodsky & Simms, 1996) resulting in a numerous positional titles to describe this position (Duffield,

1991; Johnson, Anderson, Helms, Hill & Hanson, 1995; Pedersen, 1993). There is a lack of consensus about what nurse managers do, the skills they use in management work, the functions they perform, and the role that they play in restructured health care environments (Acorn & Crawford, 1996; Beaman, 1986; Goldberg & Buttaro, 1990; Westmoreland, 1993; Zavodsky & Simms, 1996).

It is expected that restructuring the health care system can have an impact on the span of control of nurse managers. Span of control is defined as the number of employees reporting to a supervisor or manager (Daft, 1989). Little research has been done on span of control in nursing. Hence there is little guidance available to administrators when determining the span of control for first-line managers so that human and financial resources are used effectively and efficiently and quality patient care is delivered. When faced with reduced budgets, managerial positions are often eliminated in order to retain caregivers at the bedside (Pabst, 1993).

Method

Research Design

This was a descriptive study in which a structured questionnaire was used to examine the current role, scope of practice, title, educational background, attitudes and demographic characteristics of first-line nurse managers currently employed in Alberta institutions. Given the extensive health care restructuring in this province, the research was designed to answer the following questions:

(1) What are the self-reported characteristics of first-line nurse managers currently employed in Alberta?

(2) What are the self-reported roles and responsibilities of first-line nurse managers currently employed in Alberta?

(3) What are the relationships between the roles and responsibilities and the characteristics of first-line nurse managers?

Sample

The survey questionnaire was sent to 179 registered nurses living in Alberta, who held a current membership in the Alberta Association of Registered Nurses (AARN); who were employed in nursing on a regular basis and who identified their type of position as head nurse/unit manager or supervisor/coordinator. The position titles head nurse/unit manager and supervisor/coordinator were selected as the categories most likely to capture respondents in first-line management positions. Additional inclusion criteria was nurses who identified their type of employer as hospital (general, paediatric, psychiatric), rehabilitation hospital, mental health centre, nursing home/long term care centre or other type of hospital on their 1998 registration form. Eighty-four questionnaires were returned representing a 47% response rate.

Ninety-eight per cent of the sample were female. The majority of the respondents were 45 to 54 years of age (50 %). Approximately 78% indicated that they were married or living in a common-law relationship. Thirty six of the respondents (43 %) lived in a city with a population greater than 100,000. In the sample, 62 (74 %) respondents reported 16 or more years of practice as a registered nurse, while 38 (45 %) indicated they had more than ten years of management/supervisory experience. A third of the sample noted that they had five or less years of management experience. The mean time the respondents had occupied their current position was 4.8 years (SD = 5.1 years, range 0.2

to 20 years). Comparative demographic information was not available for nurse managers in Alberta.

Research Instrument

Data was collected by the means of the survey questionnaire, The Role of the Nurse Manager (RNM). The survey was a modified version of Acorn and Crawford's (1996) questionnaire. Changes were made to the format and organization of the original survey to reflect questions specific to the objectives of this study. The questionnaire consisted of six sections:

- Section A: Organization Structure (4 items)
- Section B: Position Description and Responsibilities (19 items)
- Section C: Daily activities of the Role (22 items)
- Section D: Feelings about the Organization (47 items)
- Section E: Education (12 items)
- Section F: Demographic Information (8 items).

Data Collection Procedures

Following ethical approval, permission was received from the Executive Director of the AARN to survey the study sample. A package containing a covering letter, the questionnaire, and a return self-addressed stamped envelope was mailed to 179 eligible participants. A reminder postcard was sent two weeks after the package was mailed. All mail was posted through the provincial office of the AARN so that the researcher never had access to the names or addresses of the membership ensuring anonymity of the respondents. Collection of the questionnaires was initially proposed for a six week period

but was extended five more weeks due to a national postal strike. A returned questionnaire implied the consent of the participant.

Data Analysis

The information collected from the questionnaire consisted of nominal, ordinal and interval data. Data were analysed using descriptive statistics and frequency tables. Relationships were described with Pearson's correlation's, independent t-tests, and chi-square analysis. The conventionally accepted level for Type I error ($p \leq .05$) was used and significant results were reported where applicable.

Results

Organizational Characteristics

Alberta is divided into 17 Regional Health Authorities. Fifteen of the regions were represented in the sample. The size of the organization within each region was determined by the number of beds: 45 % of the respondents worked in organizations with 150 or more beds. Information was gathered on the extent of restructuring, that is the loss of the chief nursing administrator, and the loss of nurses at the executive and first-line levels. Approximately 50% of the respondents indicated that the position of Chief Nurse Administrator was absent from their organizations. Sixty-five percent reported the loss of nurses at the executive level, while 60 % noted a reduction in the number of nurse managers in their organizations. Forty per cent of the respondents indicated the loss of their nursing department.

Hierarchical Levels

Respondents were asked "how many administrative levels are between your position and the top administrative position?" Thirteen (16 %) indicated that they reported

directly to the top administrator. Twenty-five (29%) indicated that there was one level between them and the top position, while another 54 % reported that there were two or more hierarchical levels . In contrast, the hierarchical levels reported by Acorn and Crawford (1996) pointed to flatter organizations with the majority of cases (61 %) reporting only one level between the first line nurse manager and the top position. The number of administrative levels positively correlated with number of beds ($r = .30$, $p = .05$). In other words, the larger the hospital, the more likely there is to be more administrative levels.

Positional Titles

Respondents reported a variety of titles for their positions. Fifteen different titles were identified describing the position of first line nurse manager. This information is summarized in Table 1, and is consistent with the literature. Not one participant gave head nurse as a title compared to Acorn and Crawford's (1996) study in which 51% of participants noted head nurse as their title. The participants were asked if their title had changed in the past two years and 41 managers responded that their title had changed, and 76% of this group indicated that their responsibilities had increased with the title change.

Education

Thirty-three of the respondents (39 %) reported having a baccalaureate degree, while 16 (19 %) were prepared at the Master's level. Thirty-five of the respondents (42 %) possessed a nursing diploma as their highest level of education. Fourteen of the diploma prepared nurse managers indicated that they held a post-diploma certificate in nursing management. Nineteen respondents were enrolled in education programs including baccalaureate nursing degree (58 %), post-diploma certificate (21%), and

masters or doctorate preparation (11 %). The respondents in this survey had higher levels of education than their national counterparts. In Canada, for the year 1996, highest levels of education reported for head nurses was diploma in nursing (70%), baccalaureate degree (27%), and graduate degree (3%) (Statistics Canada, 1997).

Forty-five per cent of the respondents, who were not currently enrolled in a specific program, suggested that they might consider education in the future. Family responsibilities (49 %), busy schedules (44 %), no interest in pursuing further education at this time (30 %), and financial constraints (29 %) were cited as the most frequent reasons for not being presently enrolled in an education program.

One quarter of the respondents indicated that their educational preparation was inadequate for their present position. Forty-three nurse managers (51 %) suggested that a baccalaureate degree was necessary preparation for a nurse manager, while 21 respondents (25 %) indicated that preparation at a Masters level (nursing or other discipline) was required.

Ninety percent of the respondents had attended workshops or conferences in the past two years. Participants were asked to list the type of conferences attended. The resulting information was a mixed response of clinical courses related to their areas of practice, management/leadership conferences, computer training courses, conferences related to professional associations and workshops outlining changes to legislation. Seventy-three percent of the respondents indicated that they received some financial support for their attendance at these conferences/workshops. Participants were asked for information regarding financial support prior to restructuring, and interestingly, this type of support for conferences had only decreased by 1 % for this sample.

Roles and Responsibilities

The characteristics of the role of the nurse manager were described in terms of size of area, size of annual budget, span of control and responsibility for number of different groups of health care staff. These characteristics are summarized in Table 2. Size of area was described by number of beds. Span of control was measured by the number of full-time equivalents (FTEs) and by the number of staff directly reporting to the nurse manager. Classifications of staff refer to number of different groups of staff a nurse manager may supervise including: nursing staff, assistant managers, technical support staff (e.g. respiratory therapists), other health care disciplines (e.g. physiotherapists), housekeeping staff, and administrative or clerical staff.

Size of area

The size of the area managed ranged from 4 to 250 beds. Many of the nurse managers were responsible for several types of services within this bed composition. For example, one manager was responsible for a diverse area composed of an obstetrics/gynecology unit, paediatric unit, medical/surgical unit, emergency, operating room and intensive care area. Another manager indicated responsibility for an inpatient unit, ambulatory care unit, operating room. emergency room, and an ambulance program. The 14 areas managed by the respondents are summarized in Table 3.

Span of Control

In this study, the number of staff directly reporting to the nurse manager ranged from 3 to 261 and from 2.5 to 114.0 full-time equivalents. Thirty-two percent of the respondents reported managing 75 or more staff. The number of staff reporting to a manager was positively correlated to the number of beds in the organization ($r = .24$,

$p < .05$), the size of the annual budget ($r = .76$, $p < .0005$), number of beds in the manager's portfolio ($r = .38$, $p < .0005$). In other words, the span of control of the manager seems to be influenced by the size of the organization, the size of budget, and the number of beds in his or her portfolio. Span of control was not related to the type of secretarial support or computer support. Independent t-tests were done to determine if there were any significant differences between span of control and the educational preparation of the manager, years of managerial experience, and type of setting (urban or rural). No statistical differences were found between span of control and the preceding variables.

The number of different classifications of staff reporting to the nurse manager varied. Twenty three participants (27 %) indicated responsibilities for four or more different staff classifications, while 16 managers (19 %) were solely responsible for nursing staff. The mean number of collective agreements administered was three. This is consistent with the number of different classifications of staff reporting to the nurse manager. One manager reported responsibility for administering seven different collective agreements. Generally there is a wide span of control for most of the nurse managers.

Administrative Support

Participants were asked to provide information on their clerical support, access to a computer and the presence of assistant managers. Seventy-two percent of the respondents indicated they had shared clerical support, 19 % indicated they had no clerical support, while only 7 % had a secretary fully dedicated to them. There was no relationship found between type of clerical support and size of area, annual budget or span of control. Over one half of the respondents (52 %) had their own computer, 27 % had

shared access and 20 % did not have any computer access. There was no relationship found between type of computer access and size of area managed, budget or span of control.

Ten respondents indicated that an assistant manager reported to them: four managers in medicine, three with combined units in rural areas, two in surgery, and one in long term care. Independent t-tests were done between the presence of an assistant manager and size of annual budget, number of staffing classifications, number of staff, and number of beds managed. There were no statistical differences found between presence of an assistant manager and the aforementioned variables with the exception of number of staff. There was a significant statistical difference between the mean numbers of staff and the presence of an assistant manager ($t = 2.062$, $p = .04$).

Clinical and Education Support

Participants were asked to provide information on clinical and education support in their areas. The presence of clinical nurse specialists was identified in 26 % of the areas. Only three rural area managers identified this type of position in their areas compared to 17 of the larger urban centres. Less than half of the managers had access to a nurse educator specifically for staff education, and 10 % reported having an educator responsible for patient teaching. Twenty percent identified a coordinator or supervisor responsible for after hour and weekend support.

Chi-square analysis was used to determine if there were differences between rural and urban groups and the presence of education support staff. This analysis resulted in a significant difference between rural and urban groups and the presence of clinical nurse specialists and clinical educators for staff education ($\chi^2 = 14.497$, $df = 1$, $p < .0005$ and

$\chi^2 = 7.740$, df = 1, $p < .005$ respectively). Cross tabulations of the results indicated a lower number of clinical nurse specialists than expected in the rural areas (expected = 10.3 and actual = 3). Similarly, cross tabulations of the results for the presence of a clinical staff educator were lower than expected (expected = 16.9 and actual = 11).

Impact of Fiscal Restraint

Respondents were also offered an opportunity to respond to a series of open-ended questions regarding the impact of fiscal restraint on their role. Fiscal responsibility, increased collaboration and networking, increased autonomy, new opportunities and challenges, and provision of better patient care services were cited as positive outcomes. The negative consequences for these managers in this climate of fiscal restraint were: increased workload, decreased visibility, lack of time, delayed decision-making, and lack of leadership and direction from senior administration. Strategies that had been implemented to work more effectively with limited resources centered around staffing. The respondents indicated that they had changed staffing patterns, altered staff mix, floated staff between areas and cross-trained staff to assume different duties. Finally, participants were asked to list factors that would make their jobs easier in this present climate. The most frequent request was for secretarial and computer support. Many managers also requested support from senior management: improved communication, realistic deadlines, decreased chain of command, and more contact with senior managers.

Discussion

The purpose of this study was to provide information about nurse managers specifically those in Alberta after significant health care restructuring. There were several limitations including the sampling method, the generalizability of the findings, the use of a

survey questionnaire which consisted mostly of fixed alternative responses and descriptive data that was not amenable to higher level statistical analysis. However despite these limitations, this initial study provides preliminary data about the characteristics and scope of responsibilities for this group of nurse managers.

The majority of nurse managers who responded were within the 45 to 54 years age group. It is not surprising that the age of this sample is older considering the reported years of nursing and management experience. Thus the many of the respondents are individuals nearing the end of their professional worklife. Participants in this study were prepared at baccalaureate and master's levels at higher rates than their national counterparts, yet one quarter of this group still indicated that they were inadequately prepared for their current positions.

The word "nurse" was missing from many of the reported titles in this study. This appears to be part of a growing trend that deliberately leaves out the credential of nursing. Essentially this action makes the profession of nursing invisible in terms of the makeup of the organizations administrative structure (Rodger, 1996)

The dismantling of nursing departments and the loss of nurse managers as part of restructuring, leaves many health care organizations without adequate nursing leadership. Serious losses were reported for nursing at the executive and first-line levels, yet there were more hierarchical levels reported in this study than Acorn and Crawford's (1996) study. The tendency toward flattened organizations was not shown in as many cases as was expected. This may be due to the fact that regionalization has created more senior level positions, albeit non-nursing, that have increased the number of levels between the first-line and top executive positions. It was also noted that there was a lack of

understanding or misinterpretation of this question where some respondents under-reported all hierarchical levels. As more levels could potentially have been reported, there would be an even larger number of levels between the first-line and top position.

The reported span of control in this study presents special challenges when managing large numbers of staff, often in different classifications, in organizations where 24 hour patient care is provided. It is no longer the norm to manage one area with twenty nursing staff and a budget of one million dollars. Span of control could not be related to many other variables. This suggests that the large of staff numbers and numerous classifications of staff was rather an arbitrary assignment and was not based, for example, on the experience or education of the manager. There also appears to be few administrative supports for nurse managers working in these expanded roles. Only seven per cent of the managers had secretaries fully dedicated to them. When clerical support, computers, and assistant managers are unavailable, nurse managers are challenged to do more with less assistance. This observation is further supported by the managers in this study who requested secretarial and computer support as factors that would make their job easier in this climate of fiscal restraint.

Conclusion

The results of this study provide new insights into the roles and responsibilities of nurses in first-line management positions. A diversity of titles for nurses in these positions was found in this study, and the results are consistent with findings in the literature. Generally, these nurse managers had large portfolios with wide spans of control, budgets greater than two million dollars, more than one unit to manage, and numerous classifications of staff reporting to them. In light of the larger scope of responsibilities,

there seemed little administrative support for the nurse managers in terms of computers, assistant managers and secretarial assistance. Surprisingly, one fifth of the respondents had no secretarial support at all. It is also noteworthy that there were few relationships between the scope of responsibilities and the presence of administrative supports. Furthermore, there was diminished educator support, particularly in the rural areas, leaving the nurse manager solely responsible for developing and coaching the staff in his or her area. It is striking that managers responsible for efficient and effective delivery of quality patient care and millions of scarce health care dollars are not given greater administrative and educator support.

While the reported age of this group is not particularly remarkable considering the years of nursing and management experience of the nurse managers, there is considerable concern about how these managers will be replaced. In a recently released Canadian Nurses Association (CNA) (1997) survey, there is evidence that the largest group of working nurses are in the 40 to 45 years age group. There is further evidence suggesting that individuals who are entering the nursing profession are doing so at a later age. The older new graduate will have a shorter practice period gained mostly through casual employment. A diminished pool of nurses to recruit for manager positions coupled with the growing invisibility of nursing in health care institutions potentially provides opportunities for other health care professionals to be recruited to these positions. While there is general agreement in the literature that the first-line nurse manager is essential to the success of providing quality patient care services, there are serious concerns whether the health care manager of the future will even be a nurse (McGillis Hall & Donner, 1997).

Implications

This research was designed to determine what the role of the nurse manager is within the context of health care restructuring. Information from this study can be used to describe the characteristics and scope of responsibility of nurse managers in Alberta.

Identification of the role of nurse manager can assist Regional Health Authority Boards and Senior Administrators in determining span of control, skill sets required by current and future managers, and strategies to increase retention and attract nurses to management positions. Furthermore, one fifth of the respondents did not have any clerical support. The presence of an assistant manager could not be correlated with variables such as size of budget, number of different staffing classifications, or number of beds managed. The change in the scope and nature of these positions demand appropriate administrative supports: a personal secretary or administrative assistant and a dedicated computer on a network. These types of support should not be considered as perks of the position, but as necessary tools required to support managers.

The findings in this study also point to a group of managers who wish to have more interaction with their senior administrators. The hierarchical levels reported in this study did not demonstrate the trend toward flattened organizations. More levels of reporting can potentially decrease communication and delay decision-making as was reported in this study. The challenge to senior administrators is to consider different strategies to enhance communication and support managers in first-line positions.

Although in this study, participants were educated at higher levels than their national counterparts, one quarter of the respondents still felt unprepared to meet the demands of their present positions. Educators need to recognize the need for educational

programming for nurse managers that offer course work unique to the practice of nursing management and the delivery of such education to a group constrained by family commitments, heavy workloads and limited time. Barriers have been identified that prevent nurse managers from obtaining advanced education. Educators need this information to develop strategies to enhance educational opportunities and target areas where specific education programs are required. Educators, Regional Health Authority Boards and Senior Administrators will be challenged to facilitate the availability of educational programs to meet the nurse managers' growing educational needs.

For nursing, this study has demonstrated the trend to decrease nursing administrative positions within restructured organizations. Approximately half of the respondents indicated that the position of Chief Nurse Administrator was absent in their organizations. Sixty-five per cent reported the loss of nurses at the executive level, while 60% noted a reduction in the number of nurse managers. Another 40% indicated the loss of their nursing departments. It raises the question of who is providing leadership for nurses, the largest group of health care professionals, within these restructured organizations?

Further study is recommended to determine objective indicators for determining span of control. The question whether a large scope of responsibility for the nurse manager impacts patient and staff outcomes was not answered in this study, and further inquiry into this question is recommended. As consolidated services and decreased patient length of stay in institutions have impacted community health services, a similar study of community nurse managers would provide valuable information. Health care changes are likely to continue, and therefore it is recommended that data collection describing the

nurse manager role continue over the next several years. It is hoped that these efforts would provide a better understanding of the effects of change on the role, and provide opportunities to plan for such changes.

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Table 1

First-line Nurse Manager Position Titles

Title	n	percent
Patient Care Manager	22	12
Nursing/ Unit Manager	9	17
Nursing/ Unit Supervisor	6	11
Program Manager	6	11
Care Manager	5	9
Unit/ Nursing/ Care Coordinator	4	7
Regional Coordinator	2	4
Shift Coordinator	2	4
Team Leader	2	4
Acute Care Supervisor	1	2
Assistant Coordinator	1	2
Clinical Coordinator	1	2
Nursing Care Manager	1	2
Project Manager	1	2
Senior Nurse	1	2

Table 2

The First-line Nurse Managers' Role

Characteristics	n	M	Range
Size of annual budget[a]	61	2,625,709.41	100,000 - 12,000,000
Number of beds	68	47.50	4 - 250
Span of Control			
FTEs	64	38.54	2.5 - 114
Number of Staff	73	72.96	3 - 261
Number of classifications	84	2.77	1 - 6
Number of collective agreements administered	84	2.68	0 - 7

[a]in dollars

Table 3

Areas Managed by First-line Nurse Managers

Type of Area	n	percent
Combined Units[a]	23	27
Long Term/Continuing Care	22	26
Surgery	7	8
Medicine	6	7
Child Health	5	6
No defined Area	4	5
Ambulatory Care	3	4
Rehabilitation	3	4
Women's' Health	3	4
Surgical Suites	2	2
Emergency	2	2
Mental Health	2	2
Critical Care	1	1
Oncology	1	1

[a]denotes rural areas with more than one unit type

Additional Findings

The purpose of this section is to report the perceptions of nurse managers following significant health care restructuring. Research findings will be presented related to the fourth research question: "What are the perceived impacts of health care changes for first-line nurse managers" that could not be accommodated in the paper for publication. Nurse managers were offered an opportunity to respond to a series of open-ended questions within the survey questionnaire concerning their management roles within the context of health care restructuring (Appendix A).

Method

The process of content analysis was used to examine the data. The first step in this process was to look for themes in the responses. Key words or ideas were grouped into mutually exclusive categories. Frequency tabulations were developed for these categories indicating how often the response occurred. The data was then described in terms of how frequent a response occurred (Brink & Wood, 1994). Four of the questions were subjected to content analysis:

1. What are the three positive and three negative ways the present climate of fiscal restraint has impacted your role as nurse manager? (Question C20)
2. What strategies have you implemented or are planning to implement to work more effectively with limited resources? (Question C21)
3. What factors would make your job as a nurse manager easier in this present climate? (Question C22)
4. How important is it for a person in your position to be a nurse? (Question B3b)

Data Analysis

Positive Impact of Fiscal Restraint

The participants were asked to list three positive ways the present climate of fiscal restraint in Alberta has had an impact on their role as nurse managers. Seventy-five respondents answered this question. Five nurse managers stated they were unable to report anything positive, one participant stated "I'm sorry but I can't think of any positives, they are outweighed too much by the negatives"(# 41)*. Another noted: "I can't think of too many positives other than recognizing my own personal strength in maintaining mental health" (# 70). Others responded with a variety of comments and five major themes emerged from the data. The five major themes included: fiscal responsibility, increased collaboration and networking, increased autonomy, new opportunities and challenges, and the provision of better patient care services. Each of these themes will be discussed individually with examples taken from the surveys.

Fiscal responsibility was the most common theme. Managers identified issues related to the budgeting process, decreased wastage, standardization of purchasing, and general efficiencies that made them more responsible stewards of their resources. There was a sense in their responses that decreased resources had forced them to utilize the resources they had more effectively and efficiently.

Increased collaboration and networking was identified as the second most frequent theme. Nurse managers indicated that within this climate of fiscal restraint, there

*code number assigned to each participant

was increased collaboration, both inside the organization and regionally. This collaboration extended to working with other managers, individuals in other disciplines, and physicians. The outcome of this collaboration and networking was additional resources

for the individual manager.

Increased autonomy was the third most common theme. Respondents did not elaborate on how their autonomy was enhanced by fiscal restraint. Perhaps the managers freedom has been increased by regionalization and the reduction in number of nurse managers i.e., there are fewer individuals around to monitor the manager's daily activities.

New opportunities and challenges were identified by many of the managers with some indicating that restructuring had afforded them the opportunity to successfully compete for new management positions or to be responsible for more challenging or larger areas.

Provision of better patient care services was the final theme. Some managers identified that restructuring had allowed for the improvement of patient care delivery: Community and institutional services consolidated into one building, improved discharge planning, and increased family support and involvement. One manager did note that "(the) purposes for consolidation of services (were) excellent - the processes have been difficult" (#40).

Negative Impact of Fiscal Restraint

The respondents were also asked to list three negative ways the present climate of fiscal restraint in Alberta has had an impact on their role as nurse managers. Seventy-eight responded to this question. The responses were varied. Some managers focused on how

they were personally affected by the changes, while others reported negative changes to their work environments, specifically the organization and the staff reporting to them. Issues of increased workload, decreased visibility, and not having enough time to complete work were common responses. There were numerous comments about delayed decision making, the political nature of decision making, and the lack of direction from senior administration. The difficulty of managing poor staff morale was identified as a negative outcome of fiscal restraint

Strategies Implemented to Work More Effectively

Respondents were asked to list strategies that they had implemented to work more effective with limited resources. Seventy-four managers responded to this question. The majority of the responses centered around staffing. These managers indicated that they had changed staffing patterns, altered staff mix, floated staff between areas and cross-trained staff to assume different duties. Other managers reported improved time management skills: delegation, prioritizing, and reviewing their attendance at certain meetings and their participation in committee work.

Factors that Would Make Job Easier

The participants were asked to list the factors that would make their job as a nurse manager easier in this present climate. Seventy managers responded to this question. Most of the responses centered around the concept of support. Four elements of support were identified during data analysis. The first element was secretarial and computer support. Nurse managers indicated that they required assistance with their work, one respondent indicated that she had better computer resources at home than she did at work. Others indicated the need for an assistant or the formation of an additional manager

position to assist with the increased workload. The second element was support from senior administration. Many respondents indicated the need for leadership from the top, improved communication, general support, more contact with senior managers, realistic deadlines and a decreased chain of command. The third element was clinical support. Managers noted their job would be easier if there was more front-line staff and nurse educator support. The rationale for this type of support was that less time would be spent dealing with staffing shortages and providing staff education. Finally there was a request for increased support from departments like Human Resources, Finance, and Information Systems. One manager commented that the cutbacks had forced her to assume functions formerly delivered by Human Resources.

The Importance of Being a Nurse

Participants were asked to rate on a five point Likert scale, with one being not important and five being very important: "How important is it for a person in your position to be a nurse?" The total mean response score was 4.71 indicating that most participants felt it was important to be a nurse in their current position. The mean response scores for the rural respondents was 4.9 and for the urban respondents was 4.6.

Independent t-tests were done to determine if there were any significant differences between the reported scores and geographical location, age of the respondents, education preparation and years of management experience. There were no statistical differences found between the mean scores and the groups where age, experience and education were a factor. Yet, there was a significant statistical difference ($t = 2.4$, $p < .0005$) between the mean scores for how important it was to be a nurse and the rural and urban groups.

Participants were also asked to provide explanation for their score. While all the participants answered the scoring question, only 62 responded to the second part of the question. Only urban respondents rated the question with a score of three or less suggesting it was less important to be a nurse because: "I manage areas that do not have any nurses" (#5), "program management looks to management skills, team building skills, budgetary skills...clinical base is less critical"(#38), "there are currently social workers and nurses in the position I am...a significant percentage of the job depends on management leadership skills as opposed to clinical" (#53) and "AARN registration was removed from job requirements in the last two months"(#55).

Those respondents who rated the question as moderately important to very important had various responses to support their score. Ten individuals (nine in rural centres and one in an urban centre) were required to participate in direct patient care activities and required clinical competence in their positions. The majority of the respondents indicated acting as a clinical resource person was paramount to their positions, as one manager stated: "I feel it takes nursing knowledge and experience to lead a team of nurses to meet established nursing care standards, to identify clinical problems and to effectively resolve these problems in the best interests of patients and staff" (#5). Another respondent noted: "inpatient clinical management of acute care units requires knowledge of clinical issues, experience with the complexity of clinical decision making and union environments, and to promote the clinical growth of the majority of staff (nurses)" (#34).

Discussion

The purpose of this analysis was to examine the effects of restructuring on first-line managers working in institutional settings. Participants were asked to respond to various questions regarding a climate of fiscal restraint. Most nurse managers were able to identify positive outcomes of fiscal restraint. A positive outcome of restructuring, demonstrated in this study, has been collaboration. One possible explanation is that regionalization has forced individuals in previously isolated organizations to work in collaboration, particularly in their own regions. In some cases, this spirit of cooperation has improved the delivery of patient care services.

Negative effects of fiscal restraint were also examined. Workload issues, lack of time, and decreased visibility were identified by some of the managers. These comments are not remarkable considering other findings in this study that reveal a larger scope of responsibility for most nurse managers. Managers also identified the difficulty of managing poor staff morale. It is reasonable to expect that staff have also been negatively impacted by restructuring. The larger portfolios of the managers may limit the time managers can spend time with their staff to work through these issues.

In the second question, strategies implemented to work with limited resources were examined. Nurse managers clearly expressed that changes to staffing patterns and staffing mix were implemented to work effectively with limited resources. These practices, while potentially producing cost savings, may also contribute to lower job satisfaction and morale among staff affected by these changes.

In the third question, participants were asked to describe factors that would make their job easier in the climate of fiscal restraint. Nurse managers clearly expressed the

need for support. The request for secretarial and computer support reinforces the findings that managers are working with little administrative supports.

Although the findings from this study are limited, most of the nurse managers claimed that it was important for someone in their position to be a nurse. The findings may reflect a bias as all these managers are nurses. Yet, most of the managers could articulate the need for a nurse to be in this position in terms of supporting clinical decision making and nursing standards. Clearly for the managers providing direct patient care, being a nurse was a necessary requirement of their position. There has been little written on the practice of replacing nurse managers with other health care professionals or non-health care professionals. The nurse managers in this study have suggested that being a nurse is important in a first-line management position. Clinical competence and nursing knowledge and skill were considered as important attributes for managing patient care areas. At the very least, these factors should be considered in the recruitment of individuals for first-line management positions.

Conclusion

Analysis of responses to these open-ended questions only provides limited insight into the impact of restructuring on first-line nurse managers. Evidence from these few questions suggest that nurse managers have been impacted by restructuring. Managers identified strategies that were implemented to work more effectively with limited resources, and factors that would make their jobs easier in a climate of fiscal restraint. Although the findings of this analysis provide insight into how nurse managers are working in a restructured environment, it is possible that other nurse managers would have different experiences to report. An opportunity to observe and interview managers

in their work environments may provide additional information. It is recommended that future research in this area include observation and interviewing of nurse managers. Because this study only pertained to nurse managers in institutional settings, study of managers in community settings would be beneficial. Finally, another area for future research is a closer analysis of ways, if any, that a nursing background enhances the effectiveness of the role of the first-line manager.

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Appendix A

Respondent ID # _____

Note: You cannot be identified by this number

The Role of the Nurse Manager

Questionnaire Instructions

Please read each question carefully. Circle the response which is most appropriate. Unless otherwise specified, choose only one response per question. Please answer each question as accurately as you can.

This questionnaire should take approximately 30 minutes to complete.

Thank you for your time in completing this questionnaire.

Please return by November 28, 1997

CONFIDENTIAL

This questionnaire contains 18 pages.

SECTION A - Current Organizational Characteristics

The following four questions relate to your current employer. Please circle the number which best describes your organization.

A1. What Regional Health Authority do you work in?

Region 1 - Chinook Health Authority.....1
Region 2 - Palliser Health Authority.....2
Region 3 - Headwaters Health Authority.....3
Region 4 - Calgary Health Authority.....4
Region 5 - Health Region #5.....5
Region 6 - David Thompson Health Authority.....6
Region 7 - East Central Health Authority.....7
Region 8 - Westview Health Authority.....8
Region 9 - Crossroads Health Authority.....9
Region 10 - Capital Health Authority.....10
Region 11 - Aspen Health Authority.....11
Region 12 - Lakeland Health Authority.....12
Region 13 - Mistahia Health Authority.....13
Region 14 - Peace Health Authority.....14
Region 15 - Keeweetinok Lakes Health Authority.....15
Region 16 - Northern Lights Health Authority.....16
Region 17 - Northwestern Health Authority.....17

A2. What size (number of beds) is the hospital that you work in?

50 beds or less.....1
51 to 150 beds.....2
151 to 300 beds.....3
301 beds or more.....4

A3. Is there a chief nursing administrator in your hospital?

Yes.....1
No.....2

A4. Have any of the following changes occurred in your organization? Please circle all that apply.

Loss of nurse at the executive level.....1
Decrease in the number of nurse managers.....2
Loss of nursing department.....3

Section B - Current Position

The following nineteen questions relate to your current position within the organization. Please circle the number which best describes your current position.

B1. In which area of nursing are you currently working?

Medicine.....1
Surgery.....2
Day Ward.....3
Operating Room.....4
Critical Care/ ICU/Coronary Care/Burn unit.....5
Emergency.....6
Paediatrics.....7
Rehabilitation.....8
Long Term care.....9
Other (please explain).....10

B2. Show how many administrative levels are between your position and the top administrative position.

(Top Administrator Position)
Title: _____

↑

Title: _____ or N/A ☐

↑

Title: _____ or N/A ☐

↑

Title: _____ or N/A ☐

↑

Title: _____ or N/A ☐

↑

Your Position

Continue on next page

B3. Please circle how important is it for a person in your position to be a nurse?

Not Important				Very Important
1	2	3	4	5

Please explain:

_____
_____
_____
_____

B4. How long have you occupied your current position? _____ Years

B5. Has your position title changed in the past two years?

No ..... 1 *Go to B9*
Yes 2

B6. If you answered ***Yes***, please give the exact title of your former position and your current position title:

Former Position Title: _____

Present Position Title: _____

B7. What precipitated the change in your title?

Organizational restructure 1
Change in senior management 2
Relocation 3
Other (please state) 4

B8. How did your job responsibilities change with the title change?

Increase in responsibilities 1
Decrease in responsibilities 2
No change in responsibilities 3

B9. If your title did not change, list your title: _____

B10. Are you a member of a collective bargaining unit?

Yes 1
No 2

B11. What is the size of the annual budget you administer: $_____

B12. Please complete the table below, listing all the clinical areas and staff you currently supervise:

Type of Unit/ Service	Number of Beds/Units of Service	Number of FTEs Supervised	Total Number of Staff Supervised
e.g. medical unit	*30 beds*	*21.5*	*30*
e.g. surgical suite	*N/A*	*40.5*	*60*

B13. Whom do you supervise? Circle all that apply:

Nursing staff.....1
Assistant manager.....2
Technical support staff (e.g. respiratory therapist).....3
Other health care disciplines (e.g. physical therapist).....4
Housekeeping staff.....5
Administrative/clerical staff (secretarial support).....6
Other (please specify).....7

B14. For the following nursing positions, please circle if you have these staff in your area:

Clinical Nurse Specialist/ Nurse Clinician _____ yes no
Nurse Educators - Staff _____ yes no
Nurse Educators - Patient _____ yes no
Nursing Supervisor/ Coordinator for Shift or Weekends _____ yes no

B15. Do you have 24 hour accountability for your clinical areas?

Yes.....1
No.....2

B16. Are you expected to provide on-call service for your area or program?

Yes.....1
No.....2

B17. Do you replace the person you report to in his/her absence?

Yes.....1
No.....2

B18. In your absence, are you expected to arrange coverage for your area(s)?

Yes.....1
No.....2

B19. Do you have an annual review of your performance?

Yes 1
No ..... 2 → *Go to B20*

B20. If you answered no to the above question, when was your last evaluation?

Within last 2 years 1
More than 3 years ago 2
More than 4 years ago 3
More than 5 years ago 4
More than 6 years ago 5

B21. What is your current annual salary?

$20,000 - $39,000 1
$40,000 - $ 59,000 2
$60,000 or more 3

Continue on next page

Section C - Responsibilities

The following twenty-two questions relate to your daily activities at work. Please fill in the blanks or circle the most appropriate answer.

C1. What percentage of your time is spent dealing with

Nursing related activities	_____ %
Non-nursing related activities	_____ %
	100 %

C2. How much time is spent on the following activities

Formal communication (written/verbal, other than committees)	_____ %
Informal communication	_____ %
Participation on committees	_____ %
Activities generated from committee work	_____ %
	100 %

C3. Describe your clerical support?

None 1
Shared 2
Fully dedicated to you 3

C4. Describe your access to a computer?

None 1
Shared 2
Fully dedicated to you 3

C5. Do you currently have authority to make operational or capital adjustments to your budget?

Yes 1
No 2

C6. Prior to restructuring, did you have the authority to make operational or capital adjustments to your budget?

Yes 1
No 2

C8. Please identify the collective agreements that you administer (Circle all that apply).

AUPE.....1
CHCG.....2
CUPE.....3
HSAA (professional).....4
HSAA (technical).....5
SNAA.....6
UNA.....7
Other.....8
None.....9

Please circle the number which most closely characterizes what you do in your job.

	Never	Seldom	Sometimes	Often	Always
C9 How often do you attend morning report?	1	2	3	4	5
C10 How often do you attend patient care rounds?	1	2	3	4	5
C11 To what extent are you able to act independently of you supervisor in performing your daily activities?	1	2	3	4	5
C12 To what extent are you able to do your job independently of others?	1	2	3	4	5
C13 Are you free to do pretty much what you want on the job?	1	2	3	4	5
C14. Do you have plenty of opportunity for independent thought and action?	1	2	3	4	5

Continue on next page

	Never	Seldom	Sometimes	Often	Always
C15. To what extent do you have personal control over the pace of your work?	1	2	3	4	5
C16. How frequently do you participate in the decision to hire new staff in your area?	1	2	3	4	5
C17. How frequently do you participate in the decisions on the adoption of new policies and procedures?	1	2	3	4	5
C18. How frequently do you participate in the decision to adopt new programs?	1	2	3	4	5
C19. How frequently do you participate in the decision to buy new equipment for your area?	1	2	3	4	5

Please complete the following questions:

C20. Please list 3 positive and 3 negative ways the present climate of fiscal restraint in Alberta has had an impact on your role as a nurse manager.

Positive:

1._____
_____
2._____
_____
3._____
_____

Negative:

1._____
_____
2._____
_____
3._____
_____

C21. **Please identify strategies that you have implemented or are planning to implement to work more effectively with limited resources.**

1. _____
_____
2. _____
_____
3. _____
_____

C22 **Please list factors which would make your job as a nurse manager easier in this present fiscal climate.**

_____
_____
_____
_____
_____

Continue on next page

SECTION D - Feelings About the Organization

With respect to your own feelings about the organization for which you are now working, please indicate the degree of your agreement or disagreement with each statement by circling one of the five alternatives listed below.

	Strongly Disagree		Neutral		Strongly Agree
D1. I am willing to put in a extra amount effort to help this organization be successful.	1	2	3	4	5
D2. I tell my friends that this organization is a great place to work.	1	2	3	4	5
D3. I feel a great deal of loyalty to this organization.	1	2	3	4	5
D4. I would accept almost any type of job assignment in order to keep working for this organization.	1	2	3	4	5
D5. I find that my values and the organization's values are very similar.	1	2	3	4	5
D6. I am proud to tell others that I am part of this organization.	1	2	3	4	5
D7. I could just as well be working for a different organization as long as the type of work was similar.	1	2	3	4	5
D8. This organization really inspires the best in me in the way of job performance.	1	2	3	4	5
D9. It would take very little change in my present circumstances to cause me to leave this organization.	1	2	3	4	5
D10. I am extremely glad that I made the decision to work for this organization.	1	2	3	4	5

	Strongly Disagree		Neutral		Strongly Agree
D11. There is not too much to be gained by remaining with this organization indefinitely.	1	2	3	4	5
D12. Often, I find it difficult to agree with this organization's policies on important matters relating to employees.	1	2	3	4	5
D13. I really care about the fate of this organization.	1	2	3	4	5
D14. For me, this organization is the best of all possible organizations for which to work.	1	2	3	4	5
D15. Deciding to work for this organization was a definite mistake on my part.	1	2	3	4	5

Satisfaction with Current Position in the Organization

Please indicate how satisfied you are with the following aspects of your current job by circling one of the five alternatives listed below.

	Very Dissatisfied		Neutral		Very Satisfied
D16. Salary	1	2	3	4	5
D17. Vacation	1	2	3	4	5
D18. Benefits Package (dental etc.)	1	2	3	4	5
D19. Pension	1	2	3	4	5
D20. Hours that you work	1	2	3	4	5
D21. Flexibility in scheduling your hours of work	1	2	3	4	5
D22. Opportunity to work straight days	1	2	3	4	5

	Very Dissatisfied		Neutral		Very Satisfied
D23. Opportunity for part-time work	1	2	3	4	5
D24. Weekends off per month	1	2	3	4	5
D25. Flexibility in scheduling your weekends off	1	2	3	4	5
D26. Compensation for working weekends	1	2	3	4	5
D27. Maternity leave time	1	2	3	4	5
D28. Child care facilities	1	2	3	4	5
D29. Your immediate superior	1	2	3	4	5
D30. Your nursing peers	1	2	3	4	5
D31. The physicians you work with	1	2	3	4	5
D32. The quality of care delivered in your area	1	2	3	4	5
D33. Opportunities for social contact at work	1	2	3	4	5
D34. Opportunities for social contact with colleagues after work	1	2	3	4	5
D35. Opportunities to interact professionally with other disciplines	1	2	3	4	5
D36. Opportunities to interact with the Faculty of Nursing at the University nearest you	1	2	3	4	5

	Very Dissatisfied		Neutral		Very Satisfied
D37. Opportunities to belong to department and institutional committees	1	2	3	4	5
D38. Control over what goes on in your work setting	1	2	3	4	5
D39. Opportunities for career advancement	1	2	3	4	5
D40. Recognition for your work from superiors	1	2	3	4	5
D41. Recognition of your work from peers	1	2	3	4	5
D42. Amount of encouragement and positive feedback	1	2	3	4	5
D43. Opportunities to participate in nursing research	1	2	3	4	5
D44. Opportunities to write and publish	1	2	3	4	5
D45. Your level of responsibility	1	2	3	4	5
D46. Control over your working conditions	1	2	3	4	5
D47. Your participation in organizational decision making	1	2	3	4	5

Continue on next page

Section E- Education

The following twelve questions relate to your educational background. Please circle the ,most appropriate answer or fill in the blank.

E1. Please select all educational levels that apply:

Nursing diploma 1
Post-diploma certificate in nursing management 2
Baccalaureate degree in nursing 3
Baccalaureate degree in another discipline 4
please specify.....
Masters degree in nursing 5
Masters degree in another discipline 6
please specify.....
Doctorate degree in nursing 7
Doctorate degree in another discipline 8
please specify.....

E2. Are you currently enrolled in an educational program?

Yes 1
please specify _____
No 2

E3. If you answered *No* to question *E2*, please circle all that apply to you:

Family 1
Personal financial restraints 2
No program available that provides type of knowledge I need 3
Leave of absence denied 4
No interest in pursuing further education at this time 5
Close to retirement 6
No long-distance educational opportunities 7
Too busy 8
Never considered further education 9
Have enough education to do your current job 10
May consider education at a future date 11
Other (please explain) .....

_____

E4. Do you feel your current education status adequately prepares you for your present position?

Yes.....1
No.....2

E5. What do you feel is the appropriate education preparation for a nurse manager?

Nursing diploma.....1
Post-diploma certificate in nursing management.....2
Baccalaureate degree in nursing.....3
Baccalaureate degree in another discipline.....4
Masters degree in nursing.....5
Masters degree in another discipline.....6
Doctorate degree in nursing.....7
Doctorate degree in another discipline.....8

E6. Please list the professional/academic organizations in which you hold current membership.

_____
_____
_____
_____
_____
_____

E7. Do you currently receive financial support from your organization for your professional membership(s)?

Yes.....1
No.....2

E8. Prior to restructuring, did you receive financial support from your organization for your professional memberships(s)?

Yes.....1
No.....2

E9. Please list the conferences and/or workshops that you have attended within the last two years.

_____
_____
_____

E10. Do you currently receive financial support from your organization for attendance at conferences and/or workshops?

Yes.....1
No.....2

E11. Prior to restructuring, did you receive financial support from your organization for attendance at conferences and/or workshops?

Yes.....1
No.....2

E12. What factors influence your attendance at conferences or workshops? Please circle all that apply.

Ability to network with other managers.....1
Opportunity for a break from work related activities.....2
Too busy/ too much to do to leave work.....3
No one to provide coverage for your areas while away.....4
Work accumulates while you are away.....5
Feel guilty that others must work harder while you are away.....6

Continue on next page

SECTION F -Personal Demographics

In this section of the study, please provide the following personal information. The information you provide is IMPORTANT for relating the results of the first portion of this study. Please Remember that confidentiality will be maintained at all times.

F1. What is your gender?

Female.....1
Male.....2

F2. What is your age?

18-24 years.....1
25-34 years.....2
35-44 years.....3
45-54 years.....4
55-64 years.....5
65 +.....6

F3. Please indicate the number of years of supervisory/ management experience you have.

0 to 5 years.....1
6 to 10 years.....2
11 to 15 years.....3
16 to 25 years.....4
26 or more years.....5

F4. Please indicate the number of years you have been practicing as a registered nurse.

0 to 5 years.....1
6 to 10 years.....2
11 to 15 years.....3
16 to 25 years.....4
26 or more years of practice 5

F5. What is your current marital status?

Never married.....1
Married 2
Common law.....3
Separated 4
Divorced 5
Widowed.....6

F6. Where do you presently live?

Large city (population over 100,000).....1
City (population less than 100,000).....2
Town (population more than 3,000).....3
Village (population less then 3,000).....4
Other (specify).....5

F7. What is your family income?

$20,000 - $ 39,000.....1
$40,000 - $ 59,000.....2
$60,000 - $99,000.....3
$100,000 and over.....4

F8. How would you rate your overall general level of health?

Excellent.....1
Very Good.....2
Good.....3
Fair.....4
Poor.....5

Please use the following space to make any additional comments regarding this questionnaire.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you very much for taking the time to complete this questionnaire. This information will be very useful to describe the role of the nurse manager in Alberta subsequent to recent changes in the health care system.

Please seal this questionnaire, in the envelope provided, and return by ***November 28, 1997.***

Appendix B

October 20, 1997

Dear Nurse Manager:

My name is Kim Campbell. I am a graduate student in the Faculty of Nursing, University of Alberta. I am doing a study about nurse managers and their current role within the restructured health care system. The purpose of this study is to gain a better understanding of the roles nurse managers are assuming within the restructured health care system. You have been randomly selected from the AARN membership list. I do not have access to the names of the individuals selected for this study.

Your participation in this study would involve completing the enclosed questionnaire. It will take about 30 minutes for you to complete the survey. All replies will be treated confidentially. Your name will not appear on the questionnaire.

Do not put your name on the questionnaire or on the return envelope. Participation in this study is voluntary and your consent will be implied with the return of the completed questionnaire. The responses will be safely stored in a locked filing cabinet. The information may be considered later for secondary analysis after permission has been received from an appropriate ethical review committee.

If you agree to participate, please complete and seal the questionnaire and return to me in the envelope provided. If you have any questions about this survey, please contact me or my supervisor at the telephone numbers given below. A copy of the completed study will be available at the Faculty of Nursing, University of Alberta and in the AARN library.

Thank you for your assistance in completing this questionnaire.

Kim Campbell RN, MN(C)
Faculty of Nursing
Clinical Sciences Building
University of Alberta
Edmonton, Alberta T6G 2R7
492-6708

Dr. Judith Hibberd, RN, Ph.D.
Professor/Thesis Supervisor
Clinical Sciences Building,
University of Alberta
Edmonton, Alberta T6G 2R7
492-6399

Appendix C

Questionnaire Reminder

Dear Nurse Manager:

I am doing a study about nurse managers and their current roles and responsibilities within the health care system. Within the last two weeks, you should have received a questionnaire in the mail entitled "**The Role of the Nurse Manager**". If you haven't completed this survey, this is a simple reminder and a request to complete the survey. The results of this study will assist me and others in understanding the role nurse managers in light of recent health care changes.

If you have completed and returned the questionnaire, thank you for your time and effort. Please disregard this reminder.

Thank you for your attention to this matter.

Sincerely,
Kim Campbell, RN, MN Candidate
Faculty of Nursing, University of Alberta

Appendix D
Letter to Executive Director requesting permission to use the AARN membership data bank.

August 26, 1997

Ms. Elizabeth Turnbull
Executive Director
Alberta Association of Registered Nurses
11620 -168 Street
Edmonton, Alberta T5M 4A6

Dear Ms. Turnbull:

My name is Kim Campbell. I am a graduate student in the Faculty of Nursing, University of Alberta. I am presently completing my thesis work, under the supervision of Dr. Judith Hibberd, that focuses on the role of nurse managers who currently work within the health care system.

I am writing to request permission to utilize the membership list to mail out my survey.

The survey questionnaire, **"The Role of the Nurse Manager"** has been designed and will be used to answer the following research questions:

(1) What are the self-reported characteristics of first-line nurse managers currently employed in Alberta?
(2) What are the self-reported roles and responsibilities of first-line nurse managers currently employed in Alberta?
(3) What are the relationship between the roles and responsibilities and the characteristics of first-line nurse managers?
(4) What are the perceived impacts of health care restructuring on the first-line nurse manager?

The membership population that I would like to sample are those members that have identified themselves, on the most recent registration information, as having their primary responsibilities in nursing administration (#19), their type of position as being either a head nurse/unit manager, supervisor/coordinator, or assistant/associate director (#2, 5, or 6) and their type of employer as hospital, rehabilitation hospital, mental health centre, nursing home/long term care centre or other type of hospital (#1-5).

Please find attached all information that will be included in the package to be mailed out.
The attached survey has been reviewed by a panel of experts.

I would like to mail out these surveys in October so that I may complete my thesis work by the end of 1997.

A copy of the completed study will be available at the Faculty of Nursing, University of Alberta.

Sincerely,

Kim Campbell RN, BScN
MN Candidate
University of Alberta
Faculty of Nursing